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ABSTRACT

The demands by applicants for prompt emergency services and by funding sources for greater accountability along with long waiting lists resulted in the formation of a crisis unit offering brief psychotherapy in a problem-solving framework. The services focused on: (1) the presenting problem as it reflected a core conflict or longstanding life problem; (2) a contractual treatment plan for the presenting problem with specified behavioral goals; and (3) the development of general problem-solving skills that the patient could apply to other life problems. The effectiveness of the crisis unit was evaluated by comparison to an alternative service, the intake group. The Rotter I-E Scale was administered to patients prior to and after treatment to monitor changes in internal locus of control. Statistical analysis indicated significant differences in pre- and post-test scores for the crisis unit patients (N=22) and not for the group intake patients (N=16) as well as significantly higher change scores between the two treatment groups in the pre-tests and post-tests in favor of the crisis unit patients. The findings underscore the efficacy of prompt, focused, and time-limited intervention and its advantage over a more global, supportive group intervention. (Author/JAC)

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by

Ellyn Altman, Ph.D.

Paper Presented at the Annual Meeting of the Eastern Psychological Association April 22 through April 25, 1981 in New York City.

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Crisis Intervention in a Brief Psychotherapy-Problem Solving Framework Has Mutual Benefits for Patients and Clinic

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Ellyn Altman, Ph.D.

The Catholic Charities Community Life Center of Lynbrook, committed to provide human services despite a limited number of staff, was beset with a long waiting list for clinical services. As a result its staff had great difficulty meeting the needs of people in crisis. Complicating the predicament was increasing pressure from the Nassau County Mental Health Department which has become more discriminating about granting funds for service contracts to Mental Health Clinics. Over the past years the Department has insisted on greater accountability in providing economical and efficient therapeutic services to as many people as possible and has been frowning on long waiting lists and years of extended clinic treatment.

Therefore, when three staff members volunteered to develop a Crisis Unit as a means of solving the problem of emergency patients, the administration was quick to endorse their efforts. A structure was developed which included a clinical psychologist who served as trainer and supervisor and two social workers. The focus in providing the emergency service was on (1) the presenting problem as it reflected a core conflict or long-standing life's problem, (2) a contractual treatment plan for the presenting problem with specified behavioral goals, and (3) the development of general problem solving skills that the patient could apply to other life problems. Three paraprofessional social work assistants and three clerical workers were absorbed by the Crisis Team and trained to identify emergencies, because they received the initial requests for clinical service.

For ethical reasons and commitment to providing services when it was needed there could be no control or non-treatment group. However, there was an alternative plan -- an Intake Group -- developed by staff for applicants who did not meet the criteria for admission to the Crisis Unit, but who felt they could not wait 2 to 3 months for intake and service. The Intake Group served many purposes. It enabled staff to monitor applicants

for unidentified emergencies; to provide professional and peer group support; to identify, understand and record the presenting problem with relevant history; and to provide a treatment experience that might alleviate the need for further service. Through this plan a comparative treatment group was developed while ethical standards in meeting emergencies were maintained.

SUBJECTS

There were 22 subjects (6 male and 16 female adult patients) admitted to the Crisis Unit for immediate intake and treatment based upon a set of criteria formulated by the Crisis Team. There were 16 subjects in the comparative treatment group (2 male and 14 female adult patients). They chose to attend the Intake Group.

PROCEDURE

All calls to the clinic were received and screened by the Social Work Assistants using a pre-defined set of questions and the list of criteria for admissions to the Crisis Unit. The 5 questions were designed to help the Social Work Assistants clarify the nature of the problem, evaluate its duration, and evaluat the applicant's motivation and emotional resources. The five questions were:

1. When did this problem begin?
2. What are the consequences of this problem for the applicant?
3. What are the consequences of this problem for others?
4. Is there a danger to the applicant or others because of this problem?
5. What does the applicant wish to accomplish from receiving services?

The inital criteria for admission proposed by the Crisis Team was modified and finally adopted by the clinic staff. There are three general criteria for admission. Any one of the following criteria is sufficient for admission:

1. The problem is acute and of recent onset or approximately 2 to a maximum of 4 weeks in duration.
2. The problem represents a life threatening crisis to the applicant or someone else.
3. Immediate intervention would serve a preventive measure against the development of more severe and/or intractible consequences.

To further assist the Social Work Assistants and the secretaries determine with greater ease the qualifications of the applicant a specific set of criteria was developed. The categories of problems serviced include applicants presenting suicidal threats; acute-severe depression; acute anxiety or panic reactions, psychosomatic illness of a severe physical and life threatening nature; terminal illness of the applicant or person closely related; reactions to death by intimate survivors of the deceased; severe post surgical emotional reactions to mastectomy, colostomy, amputations, disfigurement; severely actingout children and adolescents including anti-social behavior against person or property such as drug overdose, vandalism, theft; school phobia of recent onset; reactions to divorce or separation and/or involving physical abuse.

The assistant suspecting an emergency using these criteria informed the Crisis Team member on duty who did the final screening. Once an emergency was determinded, a crisis appointment was arranged for a time not exceeding 24 hours. All other applicants who did not meet the criteria for Crisis Unit admissions were informed of the weekly open ended Intake Group and were invited to attend for three sessions as an alternative to the waiting period of 2 to 3 months for individual intake interview.

One of the principles of the Crisis Intervention Model employed by the team was the expectation that personal growth can often occur in time of crisis within the framework of a structured psychotherapy. Therefore, the team established as a goal the development by the patients of problem solving skills that would contribute to a personal sense of self-sufficiency and belief in their ability to solve life's problems. While clinical data

served an important source of feedback regarding patient growth, the team wanted a more objective measure to validate the effectiveness of its work. Therefore, the patient's perceived sense of control was measured with Rotter's I-E Scale prior to the first interview. The Scale was readministered as a post-test to monitor any changes in the patients' attitudes at the end of treatment.

The intensive, in depth interview followed. This was a necessarily rigorous procedure, because the brief therapy commitment required as much information as possible initially to formulate a dynamic understanding of the applicant's presenting problem and defensive and behavioral style. This understanding was then used for the development of an immediate treatment plan which had to be mutually developed by the therapist and patient and based on realistic goals for an average of an eight session treatment.

The intensive interview consists of 3 sections and investigated (1) the presenting problem in detail from the perspective of the applicant and the interviewer including its immediate antecedents as well as its history and recurrence, (2) medical and psychiatric history, (3) family history, (4) marital history, (5) personal, social and educational history, (6) sexual development, (7) employment history, and (8) military history. There is a section for evaluation of ego functions, interviewer's impressions and recommendations for contract and treatment interventions.

Subsequent to administration of section 3 of the inital interview a psychiatric evaluation is arranged. Treatment and supervision intertwined and divided into 6 phases which included a maximum of 12 sessions but generally averaged 8 sessions. Phase 1 involved the comprehensive evaluation for the development of a dynamic understanding and formulation of tentative disposition, techniques for intervention, and a contract. Phase 2 involved an orientation for the patient, the application and education of the problem solving model, the negotiation of a mutually formulated contract with the establishment of goals and duration of treatment. Phase 3 involved a focus on the patient's social learning history for mutual understanding of the life's patterns and their relationship to the presenting

problem and an expansion of his/her cognitive, attitudinal, affective, and behavioral repertoire. Phase 4 moved into application of the problem solving principles in terms of experimenting with alternative solutions to the presenting problem often involving homework assignments. Phase 5 was the termination phase. Phase 6 involved final evaluation and determination if follow-up or extended treatment was needed.

Throughout each phase in session and in supervision there was (1) a re-evaluation of the status of the patient and the presenting problem and (2) a reminder of the goals and duration of treatment.

The people in the Intake Group were seen for 3 sessions. Each patient was discussed at the end of each group session with plans for further inquiry or support at the end of the 3 sessions for group or individual assignment, psychiatric evaluation, waiting list, or discharge with or without referral.

FINDINGS

The pre- and post- tests were evaluated statistically for changes in the measurement of the Internal Locus of Control with an increase in I or a belief in one's own ability to affect his own existence being desirable. The statistical test for the significance of the difference between two means for correlated samples was applied to the pre- and post- tests of each treatment group. The test for the Crisis Unit patients for the pre-test mean of 17.95 and the post-test mean of 19.27 yielded a $t=2.5$ with $p=.05$. The test for the Intake Group patients for the pre-test mean of 14.25 and the post-test mean of 14.8 yielded a $t=.56$ which was not significant. These results indicate an increase in attitudes of personal control over life's events for the Crisis Unit patients but not for the Intake Group patients. The two groups were compared using the test of significance for 2 independent samples which yielded for the pre-test a $t=2.56$ with $p=.05$ and for the post-test a $t=4.1$ with $p=.001$. While the patients in the Crisis Unit had higher mean scores as a group, there was a rather notable increase in the level distinguishing them from the Intake Group patients; viz.,

movement from p=.05 to p=.001.

IMPLICATIONS AND CONCLUSIONS

The two groups were different from the point of view of severity of the presenting problem. Therefore, one might more equitably start by comparing each group to itself in terms of change. It is noteworthy that despite the greater severity of the Crisis Unit problems and the greater emotional turmoil of the patients, the patients were able to use clinical services to increase their I scores or their sense of personal control and within a specified and limited period of time solve their problems, and return to previous, if not improved levels of functioning.

The Intake Group patients had not made gains toward increases in sense of personal control and were, despite the group intervention, in need of further services. It is, however, important to note that the Group Intake patients did not regress further nor did they become emergencies which is very often seen when patients must remain on the waiting list.

In summary this study underscores the efficacy of prompt, focused and time limited intervention and its advantage over a more global, supportive group intervention.